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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

INTRODUCTION

Attachment 4.19-A describes the inpatient hospital reimbursement methodology for fee-for-service (FFS) payments made by the Arizona Health Care Cost Containment System Administration (AHCCCSA) to hospitals under both the AHCCCS acute care and the Arizona Long Term Care System (ALTCS) programs. Because the AHCCCS and the ALTCS programs operate on a prepaid capitation basis, the majority of inpatient hospital services received by AHCCCS and ALTCS members are provided through and paid directly by contracting health plans or program contractors. However, inpatient hospital services provided to certain off-reservation Indian Health Services members, Emergency Services Only populations, and special cases are paid on a FFS basis.

Beginning with admission dates of October 1, 1999 and thereafter, FFS payments to hospitals will be made in accordance with a prospective, tiered per diem reimbursement system. For each day of care which meets medical necessity and other applicable authorization requirements, hospitals will receive one of seven per diem rates appropriate to the type of service rendered. The tiered per diem payment methodology does not apply to: organ transplants (with the exception of cornea transplants which are reimbursed under the tiered per diem methodology) and bone marrow transplants, other specialty services, out-of-state hospitals, and freestanding psychiatric hospitals. This submittal is organized into seven sections:

- Definitions
- General Description of the Tiered Per Diem Rate Structure
- Rate Setting Methodology
- Payment to New and Out-of-State Hospitals, and for New Programs
- Payment to Freestanding Psychiatric Hospitals
- Appeals Procedures
- Public Notice

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I. DEFINITIONS

A. AHCCCS Days of Care

Inpatient hospital days of care that are eligible for payment under this plan are defined as the admission day and each day of stay except the day of discharge, provided that all medical necessity and authorization requirements have been met. If a member who is an inpatient dies, the date of death (date of discharge) is paid provided all medical necessity and authorization requirements have been met. Except in the case of death, hospital stays where the day of admission and discharge are the same are called same day admit and discharge claims, and are paid as an outpatient hospital claim (including same day transfers). Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid the lesser of the maternity/nursery tier rate or the outpatient cost-to-charge ratio multiplied by covered ancillary and accommodation charges. A claim must be legible, error free, and have an accommodation revenue code and an allowable charge greater than zero to receive payment as an inpatient hospital day.

B. New Hospital

A new hospital is any hospital for which Medicare Cost Report data and AHCCCS claims and encounter data are not available from any owner or operator of the hospital for hospital rate development, during the rate-setting year.

C. Operating Costs

Operating costs are defined as allowable accommodation and ancillary department hospital costs, excluding capital and direct medical education.

D. Outlier

Outliers are hospital claims in which the operating costs per day are extraordinary. AHCCCS shall set the statewide outlier cost threshold for each tier at the greater of:

1) Three standard deviations from the statewide mean operating cost per day within the tier; or

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2) Two standard deviations from the statewide mean operating costs per day across all tiers.

Because hospitals submit charges rather than costs on claims and encounters, AHCCCS sets hospital-specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceed the hospital-specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are two tiers on a claim or encounter, AHCCCS shall determine whether the claim or encounter is an outlier by using a weighted threshold for the two tiers. The weighted threshold is calculated by multiplying the threshold for each tier by the number of AHCCCS inpatient hospital days of care for that tier and dividing the product by the total tier days for that hospital.

E. Peer Group

A peer group consists of hospitals which share a common and stable characteristic which significantly influences the cost of providing hospital services when measured statistically.

F. Prospective Rates

Prospective rates are inpatient hospital rates defined in advance of a payment period and represent payment in full for covered services excluding any quick-pay discounts, slow pay penalties, and third party payments regardless of billed charges or individual hospital costs.

G. Prospective Rate Year

The prospective rate year is the period from October 1 of each year to September 30 of the following year.

II. GENERAL DESCRIPTION OF THE TIERED PER DIEM RATE STRUCTURE FOR INPATIENT SERVICES

For admissions on and after October 1, 1999 AHCCCS will reimburse in-state acute care hospitals for each AHCCCS day of care with a prospective per diem rate representing payment for both ancillary and accommodation services. Each AHCCCS day of care is classified into one

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of seven service categories (tiers) and is paid the per diem rate corresponding to that category unless the claim is identified as an outlier claim, or is for a covered organ (with the exception of cornea transplants which are reimbursed under the tiered per diem methodology) or bone marrow transplant or other specialty services which may be paid under separate contract arrangements. This section describes the structure of the tiered per diem payment system.

A. Tiered Rate Structure

Medically necessary AHCCCS days of care that meet all medical review and authorization requirements are assigned to tiers based on information submitted on the claim. The classification logic examines revenue codes, diagnostic and procedure code information, and peer groups as applicable. Assignment to a tier follows the ordered, hierarchical processing described below. It is possible for some AHCCCS days of care on a claim to be classified into one tier and the remaining AHCCCS days of care on the claim to be classified to a different tier for payment purposes. A claim can never have AHCCCS days of care paid on the basis of more than two tiers. If a claim has no charges associated with an accommodation revenue code it is not considered an inpatient day for payment.

The following are the seven tiers:

1) **Maternity:** The maternity tier is identified by a primary diagnosis code within the range of 640.XX - 643.XX, 644.2X - 676.XX, V22.XX - V24.XX or V27.XX. If a claim has a primary diagnosis within one of these ranges, all the days on the claim are paid at the maternity tier rate.

2) **NICU:** The neonatal intensive care tier is identified by a revenue code of 174. For a hospital to qualify for the NICU per diem, the hospital must be classified as either a level II or level III perinatal center by the Arizona Perinatal Trust. All of the days on the claim with the NICU revenue code that meet the criteria for the NICU tier will be paid at the NICU per diem. Any remaining days on the claim are paid at the nursery tier rate.

3) **ICU:** The intensive care tier is identified by a revenue code in the range of 200-204, 207-212 or 219. All of the days on the claim with an ICU revenue code that meet the criteria for the ICU tier will be paid at the ICU rate. If there are days on the claim without an ICU revenue code, they may be paid at the surgery, psychiatric or routine tier rate.

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4) **Surgery:** The surgery tier is identified by a revenue code of 36X in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgery procedure list. This excluded procedure list identifies minor procedures such as sutures which do not require the same hospital resources as other procedures. If these conditions are met, and the surgery was performed on a date after the person was determined AHCCCS eligible, any day that is not associated with an ICU revenue code is paid at the surgery tier rate.

5) **Psychiatric:** The psychiatric tier is identified in either of the following ways:

   a. A psychiatric revenue code within the range of 114, 124, 134, 144 or 154 and any psychiatric diagnosis in the range of 290.XX - 316.XX; or

   b. Any routine revenue code if all diagnosis codes on the claim are within the range of 290.XX - 316.XX.

   A claim with day(s) paid at the psychiatric tier rate, may also have day(s) paid at the ICU tier rate.

6) **Nursery:** A revenue code of 17X (excluding 174) is required to classify a day into this tier for payment at the nursery tier rate. A claim with day(s) paid at the nursery tier rate may also have day(s) paid at the NICU tier rate.

7) **Routine:** Other days associated with revenue codes within the following ranges that are not classified into one of the tiers listed above are paid at the routine per diem rate: 100-101, 110-113, 116-123, 126-133, 136-143, 146-153, 156-159, 16X, 206, 213 or 214.

Any day which does not group into a tier is pended for examination and may require additional information to be submitted before tier classification can occur.

B. Payment of Outliers, Transplants and Other Specialty Services

This section describes certain exceptions to the tiered payment rates for special cases in acute care hospitals.

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1) **Outliers**: AHCCCS shall reimburse hospitals for outlier claims by multiplying covered charges by the statewide average inpatient cost-to-charge ratio inclusive of capital. For rates effective on and after October 1, 1999, outlier cost and charge thresholds shall be updated annually by the Data Resources Inc. (DRI) Prospective Payment System Hospital inflation factor.

2) **Transplants**: Organ transplants (excluding cornea transplants) and bone marrow transplants are not reimbursed under the tiered per diem system. AHCCCS shall reimburse hospitals for an acute care stay in which a covered organ (excluding cornea) or bone marrow transplant was performed either through the terms of any relevant contract agreement; or, in the absence of a contract, by multiplying covered charges by the statewide inpatient cost-to-charge ratio inclusive of capital.

3) **Specialty Services:** AHCCCS may negotiate special contracts for specialized hospital services, including but not limited to: subacute, neonatalogy, neurology, cardiology and burn care.

III. RATE-SETTING METHODOLOGY

The final payment for each tier is the sum of two separate components: operating and capital. This sections describes each component and how it is calculated. Five of the seven tiers are statewide. The NICU tier is peer grouped for NICU Level II versus NICU Level III, as certified by the Arizona Perinatal Trust. The Routine tier is peer grouped for rehabilitation hospital versus general acute care hospital.

A. Base Operating Component

The operating component of the rate represents the weighted average operating cost per day for treating AHCCCS patients in that tier across all acute care hospitals in Arizona with two exceptions:

Exception 1: For the Routine tier, the component represents the weighted average operating cost per day by peer group. The peer groups for the Routine tier are rehabilitation hospitals, and general acute care hospitals.

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Exception 2: For the NICU tier, the component represents the weighted average operating cost per day by peer group. The peer groups for the NICU tier are NICU Level III hospitals, and NICU Level II hospitals, as certified by the Arizona Perinatal Trust.

The computation of the operating component, and the application of inflation factors to the operating component, are described in the following paragraphs.

1) **Computation of Operating Cost:** Operating costs were computed based on a claim costing process involving cost report data and claims/encounter data for each hospital:

a. Hospital cost reports for fiscal years ending in 1996 served as the cost report data base. The cost report data provided ancillary department cost-to-charge ratios and accommodation costs per day. Cost-to-charge ratios were calculated for each hospital department. Cost-to-charge ratios were capped at 1.00 for each department. Because hospital cost report years are not standard, prior to calculating rates cost per diems were inflated to a common point in time, December 31, 1996, using the DRI inflation factor. Capital and medical education costs were excluded for computation of the operating cost component.

b. Hospital claims and encounters were pulled that matched each hospital's Medicare FYE96 dates of service for the claims and encounters data base. Only claims and encounters that were accepted and processed by AHCCCS at the time the extract file was developed were included. Claims/encounter data were also subjected to a series of data quality, data reasonableness, and data integrity edits. Claims/encounters that failed edits were excluded from the data base. Duplicate claims, claims with missing information necessary to group into a tier, and Medicare crossover claims, among others were excluded in this process.

c. The claim and cost data bases were then combined. Because revenue codes on claims and encounters do not match cost centers or departments on cost reports, a cross walk was developed for matching.

d. Operating costs were derived from the combined cost/claim data bases by applying departmental cost-to-charge ratios for a hospital to allowed ancillary charges on each claim. Ancillary charges were inflated to December 31, 1996, using the DRI

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inflation factor. Accommodation costs were derived by multiplying the covered days on the claim/encounter times the accommodation cost per diems from the cost report.

e. Costed claims/encounters were then assigned to tiers using the logic specified above. For claims assigned to more than one tier, ancillary costs were allocated to the tiers in the same proportion as the accommodation costs.

f. All costs were reduced by an audit adjustment factor equal to four percent since cost reports were not audited.

2) **Inflation Factor**: For rates effective on and after October 1, 1999, AHCCCS shall inflate the operating component of the tiered per diem rates to the mid-point of the prospective rate year, using the DRI inflation factor.

Length of Stay (LOS) Adjustment: For rates effective October 1, 1999 through September 30, 2000, the operating component of the Maternity and Nursery tiers shall be adjusted to reflect changes in LOS as required by the federal mandate that allows women at least 48 hours of inpatient care for a normal vaginal delivery, and at least 96 hours of inpatient care for a cesarean section delivery, effective for dates of service on and after January 1, 1998. There shall be no LOS updates for any tiers for rates effective on or after October 1, 2000.

B. Direct Medical Education Component

Direct medical education includes nursing school education, intern and resident salaries, fringes and program costs and paramedical education.

For dates of service on and after October 1, 1997 (FFY98), GME payment dollars will be separated from the tiered per diem rates to create an AHCCCS GME pool. For FFY98 and each year thereafter, the value of the GME pool will be based on the total GME payments made for claims and encounters in FFY96, inflated by the DRI inflation factor. Subject to State legislative appropriations, on an annual basis GME pool funds will be distributed to each hospital with an approved GME program based on the percentage of the total FFY96 GME pool that each hospital's FFY96 GME payment represented. In

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essence, the percentage of the total FFY96 GME pool that a hospital received in FFY96 will be the percentage of the total FFY98 GME pool that a hospital receives in FFY98. New GME programs approved on or before October 1, 1999, but that did not receive a GME payment in FFY96, will receive a FFY98 GME payment based on the percentage of the total FFY96 GME pool that their FFY97 payment represented. The addition of the new programs does not increase the dollars in the AHCCCS GME pool, therefore, all hospitals with approved GME programs will receive slightly less than they would have otherwise received.

C. Capital Component

Hospitals shall receive payment to compensate for capital costs associated with treating AHCCCS members. The capital component is a blend of hospital-specific and statewide costs, as defined below.

1) **Calculation of Capital Costs**: Capital costs for each hospital are identified through a claim costing process using accommodation cost per diems and cost-to-charge ratios in a manner similar to that described for operating costs. Costs identified using ratios and per diems which include only operating are subtracted from costs identified using ratios and per diems which include capital as well as operating. The result is capital cost per claim which is summed across claims for each hospital and divided by covered days. The statewide average is calculated based on capital costs across all claims divided by covered days across claims.

2) **Blend** Capital reimbursement represents a blend of statewide and individual hospital costs. For rates effective on and after October 1, 1999, the capital component shall be frozen at the 40% hospital-specific/60% statewide blend in effect on January 1, 1999.

PROSPECTIVE RATE YEAR	HOSPITAL SPECIFIC	STATEWIDE
1 (3/1/93-9/30/94)	90%	10%
2 (10/1/94-9/30/95)	80%	20%
3 (10/1/95-9/30/96)	70%	30%
4 (10/1/96-9/30/97)	60%	40%

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5 (10/1/97-9/30/98)	50%	50%
6 (10/1/98) and after	40%	60%

3) **Capital Payment by Tier**: Capital payments effective before September 30, 2000, shall be indexed to each tier by a relative weight factor, which is calculated by dividing each of the hospital's tiered operating rates by the weighted average of all the tiered operating rates for that hospital. For rates effective on and after October 1, 2000, this weighting of capital rates by tier will be frozen at the level in effect on September 30, 2000.

4) **Annual Update:** On an annual basis, AHCCCS shall adjust the capital component by the DRI inflation factor.

D. Discounts and Penalties

AHCCCS shall subject all inpatient hospital admissions on and after March 1, 1993 to quick-pay discounts and slow-pay penalties in accordance with Arizona Revised Statute (A.R.S.) Title 36, Chapter 29, Article 1.

For dates of service or admissions on or after October 1, 1999, a quick pay discount of 1% is applied to claims paid within 30 days of the clean claim date.

Effective with dates of service or admissions on or after March 1, 1993, if a hospital's bill is paid after 30 days but within 60 days of the clean claim date, AHCCCS shall pay 100% of the rate. If a hospital's bill is paid any time after 60 days of the clean claim date, AHCCCS shall pay 100% of the rate plus a fee of 1% per month for each month or portion of a month following the 60th day of receipt of the bill until the date of payment.

IV. PAYMENT TO NEW HOSPITALS AND OUT-OF-STATE HOSPITALS, AND FOR NEW PROGRAMS

A. New Hospitals

New hospitals are assigned the statewide (or peer group) average operating cost and the statewide average capital amount for each tier, as appropriate. Capital reimbursement for new hospitals is indexed according to statewide relative weights per tier. New hospitals may